Department of Health Services
Food and Drug Branch
601 North 7th Street, MS357
P.O. Box 942732
Sacramento, CA 94234-7320
Phone (916) 445-5224
Fax (916) 322-6326

APPLICATION FOR HOME MEDICAL DEVICE RETAILER LICENSE

Read instructions on attached sheet, if not applicable write N/A; unsigned or incomplete applications will not be processed.

(Please print or type)

1. Legal Name of Home Medical Device Retailer: | Telephone Number: ( )

Business or Doing Business As (DBA)Name: | Current HMDR license No.

Address	Number and Street	City	State	Zip Code

2. Indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for-profit corporation ☐ Government owned

3. Indicate type of application:

☐ Renewal of an existing HMDR license ☐ New Home Medical Device Retailer ☐ Out of State Home Medical Device ☐ Warehouse

4. Indicate reason for application: (***Only applies to facilities that have a current HMDR license***)

☐ Change of Location of an existing Home Medical Device Retailer ☐ Change of ownership of an existing Home Medical Device Retailer

5. Correspondent Name:

6. Mailing Address (if different):	Number and Street	City	State	Zip Code

7. Type of business to be conducted at this location:

☐ Sales ☐ Distribution ☐ Storage Only (Warehouse)

8. The applicant medical device retailer will sell the following products: (***Check all that apply***)

☐ Prescription (Legend) Devices
☐ Respiratory Equipment
☐ Enteral Supplies
☐ Non Prescription Devices (DME)
☐ Incontinence Supplies
☐ Custom Wheelchairs
☐ Power Wheelchairs
☐ Manual Wheelchairs
☐ Walkers, Canes, Commodes
☐ Other: Describe Below

_____

_____

9. Original or Anticipated first day of business at current or new address:

10. Name and telephone number of person authorized to clarify information provided on this application.

( )

11. List Medi-Cal or MediCare Provider numbers.

Medi-Cal Provider? ☐ Yes ☐ No If Yes, DME Provider Number: _____

MediCare Provider? ☐ Yes ☐ No If Yes, CMS Provider Number: _____

HOME MEDICAL DEVICE RETAIL FACILITY LICENSE FEE
00000000404000000G1257004984149A3018

12. Has any disciplinary or criminal action been taken against any of the licenses in any of the states listed above? **If yes, you must attach a written explanation giving full details for your affirmative response. Failure to provide an explanation will delay the processing of your application.**	☐Yes ☐No

The section only needs to be completed if the Home Medical Device Retail Facility will be selling or renting legend devices, respiratory equipment or medical oxygen.

13. Will there be a pharmacist in charge of operations at this location? ☐Yes ☐No
If yes, provide name, license number and residence address. Attach a copy of license to application.

Pharmacist's name:		Pharmacist's license number:	
Residence address:	City:	State:	Zip Code:

Will there be an Exemptee in charge of operations at this location? ☐Yes ☐No
If yes, provide name(s) and license number(s).

Name:	Exemptee license number:
Name:	Exemptee license number:
Name:	Exemptee license number:

14. **Ownership** - Name and title of owner or Corporate Officers. Name and address of parent firm or headquarters **if different** from facility address.

Owner:_____

Address of Parent Firm/Headquarters (***If different from facility address***) :

_____

_____

The Food and Drug Branch must approve this application before a Home Medical Device Retailer license is issued. If changes are made during the application process, you may need to submit a new application with appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in response to any question is grounds for refusal or subsequent revocation of license, and a violation of the Penal Code of California. All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under the California Health and Safety Code. The official responsible for information maintenance is the Chief, Food and Drug Branch, 601 North 7th Street, MS-357, P.O. Box 942732, Sacramento, California 94234-7320, (916) 445-5224. The information may be transferred to another governmental agency if necessary for it to perform its duties.

15. Certification of Applicant – Please read carefully and sign below

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says: (1) He/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) that no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date

Home Medical Device Retailer License Application Instructions

A separate application is required for each place of business. Please complete and/or amend this application as is most appropriate to your facility. Include the appropriate fee for each application as indicated in the fee schedule and payable to: CALIFORNIA DEPARTMENT OF HEALTH SERVICES. This fee must accompany this application; or else the application cannot be processed. For renewals, penalty for failure to apply within 30 days after expiration is an additional $10.00 that must be added to the renewal fee before the license is issued. Unsigned or incomplete applications cannot be processed. The following are further instructions on how to complete this application:

1. **Your Firm Information:** The name of the home medical device retailer to appear on the license issued by the Department of Health Services. This should be the same name that appears on your business license or your Federal Employer Identification Number (FEIN). DBA is the name you use as a "Doing Business As" name. *Address*: is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State:* is normally California but will be different if your firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
2. **Type of Ownership:** Check or mark the block to indicate the firm's type of ownership.
3. **Type of Application:** Check or mark the block to indicate if this application is for a new firm license, renewal of an existing license, out of state license or warehouse. A warehouse must also have an HMDR facility associated with it.
4. **Reason for Application:** Indicate if the reason for the application is a change of an existing firm's location or change of an existing firm's ownership. ***This section only applies to facilities with an existing license.***
5. **Correspondent Name***:* Fill in the name of the person who will normally keep track of the Home Medical Device License and associated records and be responsible for applying for and renewal of this license.
6. **Mailing Address:** This address is where licensing information is to be sent if the address is a different location than the location of firm where business will take place.
7. **Type of Home Medical Device Business:** Check or mark one or more blocks to indicate the most similar to the type of business occurring at this facility. Sales and storage (warehousing) often occur in the same location. Offsite warehouses must be licensed as well but at 1/2 the fee of the retail licensee. Wholesale business (including wholesale distribution) continues to be licensed by the Board of Pharmacy.
8. **Type of Products to be sold at this firm:** Check all appropriate boxes indicating types of products sold by this firm.
9. **Original or planned first day of business***:* Enter the date on which you plan to open your firm and provide full customer service.
10. **Authorized Person:** Enter the name and phone number of the person who is authorized to provide and clarify information for this firm.
11. **List Medi-**Cal or MediCare provider numbers. If the HMDR facility is currently or planning to be a provider, you must complete this section.
12. Check the block yes or no if your firm has had any action taken against its licenses held in other states.
13. **List the pharmacist in charge or Exemptee applicants for this facility***:* If your firm intends to dispense legend (prescription) medical devices you are required to hire either a registered pharmacist in charge or an Exemptee. List below the name of the pharmacist or Exemptee(s) hired by your firm.
14. **Ownership:** List the name and title of the owner or corporate officers. List the name of the parent firm or headquarters if the address is different from the Home Medical Device Retail facility listed.
15. **Certification of Applicant(s):** After reading the instruction paragraph, signatures are needed from the business owner (sole proprietor), business partners, or corporate officers attesting to the contents of the application. Please sign; print name, state title of signatory and date the signature in the boxes provided. Mail the completed and signed application with the licensing fee(see table below) to:

Department of Health Services
Food and Drug Branch - Licensing
PO BOX 942832
Sacramento, CA 94234-0006

License Category	*Fee*	*Interval*	*New Application*
Instate retail firm	$850.00	Annually on renewal	On application
Out of State retail firm	$150.00	Annually on renewal	On application
Warehouse only	$425.00	Annually on renewal	On application
Exemptee Application Fee	$100.00	Once on application only	On application
Exemptee License Fee	$150.00	Annually on renewal	On application
Government agency	$0.00	Annual renewal required no fee due	No fee required with application
Non-Profit agency	$0.00	Annual renewal required no fee due	No fee required with application

If you have any questions, please contact the Home Medical Device License Voice Mailbox at (916) 445-5224 and leave a message with your firm name, your name and your phone number and a staff member will return your call. You may also visit our internet web site at: http://www.dhs.ca.gov/fdb/ for timely program news and a blank copy of this application form.